Contents

Phone numbers, addresses and web site addresses mentioned in this guide can be found in the Helpful Information section at the end of this guide.

Pathways to Your Benefits

Each day we confront challenges, make decisions, and choose particular pathways to follow. In retirement, those pathways may be familiar or they could offer exciting new opportunities. To help you create a successful retirement for you and your family, the County is proud to provide you with a Retiree Medical Insurance program — Pathways to Your Benefits.

We know that your benefits are important to you and your whole family. We also know that you need tools and resources to help you take advantage of all your coverage has to offer. This enrollment guide is designed to help you take the first steps down the pathways to your benefits — understanding and choosing your benefits for the coming year. Inside you'll find details about the County Retiree Medical Insurance Program (RMIP) and eligibility, as well as where to go for additional information. Take some time to read through this guide carefully and share it with your family. Then you'll be ready to make the decisions that are right for you and your family.

Time to Enroll

The annual Open Enrollment period is generally during the month of November each year. This is your only opportunity to make changes to your benefits unless you have a Qualified Life Event, (QLE). You will receive information on specific Open Enrollment dates and deadlines when the time comes.

If at all possible, we encourage you to enroll well before the enrollment deadline, so that you're not left "waiting in line" to speak with a Benefits Specialist at the last minute.

The benefits you elect during Open Enrollment will be effective January 1 of the following year.

Remember, all you have to do to enroll is click or call — log on to the Benefits Center Web Site or call the Benefits Resource Line and speak to a Benefits Specialist.

▶ If You've Got Questions, We've Got Answers

If you have questions about enrollment, you can visit the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html or call the Benefits Resource Line toll-free at 1-866-325-2345 and follow the instructions to speak with a Benefits Specialist. Benefits Specialists are available Monday through Friday, 7:30 a.m. to 5:30 p.m. Pacific Time, except for holidays. If you need assistance in another language or are hearing impaired, Benefits Specialists can connect you with a translation service or TDD at no cost to you.

What to Do Now

- Read this Enrollment Guide carefully to understand how your benefits package works.

- Review the materials in your enrollment package, including:
  - **Benefits Enrollment Summary** — This summary contains information about the benefits available to you and a list of your contribution amounts. It also shows your automatic benefit coverage if no elections are made.
  - **Open Enrollment Meeting Schedule** — To help explain your Open Enrollment options, we setup a series of meetings in November. Find a date, time, and location that is convenient for you. Your attendance is strongly recommended.
  - **Wallet Card** — This card includes important phone numbers, Web Sites and basic instructions on how to use the Benefits Center Web Site and Benefits Resource Line.
- Enroll for your benefits before the enrollment deadline.

If You're a Current Retiree

If you're currently retired and you want to keep the same retiree health plan and dependents as shown on your Benefits Enrollment Summary, you do not need to enroll. However, ***you must enroll if you want to***:

- Add or drop dependents
- Change your retiree health plan.

You will be enrolled in the automatic coverage shown on your Benefits Enrollment Summary if you do not make any changes before the open-enrollment deadline. Review the summary, including the dependent coverage section, within the required timeframe as no changes can be made after the deadline.

Once you receive your Benefits Confirmation Statement, you must report any errors to the elections you made within 10 business days from the date on the statement.

Keep in mind that after the Open Enrollment period, you can't change your benefit elections during the year unless you have a Qualified Life Event. See Making Changes to Your Benefits later in this guide for more information.

If You're a New Retiree

If you're a new retiree of the County, ***you have 30 days from the date on your enrollment package to enroll*** in your benefits through the Benefits Center and continue your health plan coverage with the County. If you don't enroll within this period, you'll receive automatic benefits coverage under the retiree health plan equivalent to your employee health plan with the exception of the monthly premium. You'll have the opportunity to report errors to the elections you made within 10 business days from the date on your Benefits Confirmation Statement.

Your retiree health insurance coverage becomes effective on the first day of the month following your termination from County employment due to retirement. Since there will be no lapse in your health coverage, the PPO health plan pre-existing condition exclusions will be waived even if you change health plans and/or add dependents during this one-time retiree enrollment period. If you wish to disenroll from your retiree health coverage, you may be permanently disenrolled, see Important Notes About Disenrolling from Retiree Health and/or Medicare Coverage on the following page.

Deferred Retiree

You must activate your retiree medical insurance, if eligible, within 30 days of activating your OCERS pension check. If you select a PPO health plan, pre-existing conditions will apply. When calling the Benefits Center, you must self identify as a County of Orange deferred retiree.

Premium Payment for New Retirees

As a new retiree, you will automatically be placed on direct billing, if applicable, to pay for health premiums. After receiving invoices from Benefits Billing Services, please contact them directly with any questions or concerns you may have about your invoice. Between 60-90 days after you retire, your health plan premium will automatically be deducted from your OCERS pension check. If for any reason, at any time, your pension check is unable to cover your share of the health premium amount, you will be put back on direct billing.

Retiree Orientation Sessions

If you are a new retiree you are invited to attend a New Retiree Orientation. New Retiree Orientations are held on the first Monday of each month. Orientation is located in the Hall of Administration, room 214/216 at 1:00 pm. You may visit the Employee Benefits Web Site at www.ocgov.com/hr/employeebenefits for more information.

If You Change Your Home Address

If you change your home address, you must call the Benefits Resource Line and speak to a Benefits Specialist. It's important that the Benefits Center has your correct home address in order to send you important information about your Retiree Medical Plan. You should also notify any other organization, including OCERS, with which you are affiliated in regards to your change of home address.

If You Move Out of Area

If you're enrolled in an HMO plan and move outside of your plan's network, you must enroll in another HMO if available in your area or in one of the PPO plans. If you do not enroll, you'll be automatically defaulted to the Premier Wellwise PPO plan.

When You Turn 65

Three months before you or a covered spouse turns 65, you'll receive a "Turning Age 65" package from the Benefits Center, which provides information on your health plan options. You must enroll in Medicare Part A (if eligible, at no cost) and Part B in order to receive or continue to receive your Retiree Medical Plan Grant, health plan premium discounts, and maximum health plan benefits, and/or to enroll in Kaiser Senior Advantage. Retirees who gain health coverage as elsewhere following retirement will be required to enroll in Medicare once eligible. If either the subscriber or the dependent is eligible for Medicare each must enroll in A & B (Part A, if at no cost), even if they are actively working with coverage elsewhere. See the Important Medicare Information section of this guide for more information about enrolling in Medicare.

Important Notes About Disenrolling from Retiree Health and/or Medicare Coverage

You have the option to disenroll from County retiree health coverage if you are:

- Under age 65 — If you disenroll from a County retiree health plan before you enroll in Medicare, you and your dependents will be permanently disenrolling from the County Retiree Medical Plan, which includes the County retiree health plan coverage and the Retiree Medical Plan Grant, if any (described in the Retiree Health Costs section of this guide). This means you'll be prohibited from enrolling in a County retiree health plan and receiving the Retiree Medical Plan Grant in the future.
- Over age 65 — If you disenroll from a County retiree health plan but are enrolled in Medicare, you'll be permanently disenrolling from the County retiree health plan. This means you'll be prohibited from enrolling in a County retiree health plan in the future. You'll continue to be eligible for the Retiree Medical Plan Grant but the grant can only be used toward Medicare premium reimbursement. For more information on the Retiree Medical Plan Grant, see the Retiree Health Costs section of this guide.

An exception to these rules applies to a retiree who is married either to another County retiree (RMR) or to a County employee (RME). If this is your situation, please read the How the Pathways to Benefits Program Works section of this guide for more information.

The Last Step on Your Pathways to Benefits

After you enroll, you'll receive a Benefits Confirmation Statement in the mail. You can also print a statement if you enroll online. Be sure to review the statement to make sure it correctly reflects your benefit elections. If any of the information on your statement is incomplete or incorrect, call the Benefits Resource Line right away and speak with a Benefits Specialist. You'll have 10 business days from the date of your Benefits Confirmation Statement to report errors to the elections you made. If you don't receive a Benefits Confirmation Statement shortly after making your elections, please call the Benefits Resource Line right away to notify a Benefits Specialist.

Making Changes to Your Benefits

You may change your benefits between Open Enrollment periods if you experience certain Qualified Life Events. The list below defines some of the situations where a change is permitted:

- You marry, divorce, or become legally separated or your marriage is annulled
- You gain a dependent through birth, adoption or placement for adoption
- Your dependent dies
- Your dependent no longer meets the eligibility requirements
- You and/or your spouse/DP has a change in employment status that results in gaining or losing eligibility for coverage
- You or your dependent moves to a location where your current coverage is not available.

Any change in your coverage must be made within 30 days of the Qualified Life Event and must be consistent with that event. If your life event allows you to add or drop dependents, simply log onto the Benefits Center Web Site or call the Benefits Resource Line and speak to a Benefits Specialist. You may be asked to submit documentation (birth certificate, etc.) to support your elections for eligible dependent coverage. Failure to submit documentation may result in your dependent not being covered, with no benefits payable. Keep in mind that HMO contracts do not allow you to add newly eligible dependents after the 30-day period. Dependents added to a PPO plan outside of Open Enrollment are subject to the plan's pre-existing condition exclusion provision.

If you have a Qualified Life Event after the end of Open Enrollment but before the start of the new year and want to make changes to your benefits, you must call the Benefits Resource Line within 30 days of your Qualified Life Event. You may need to confirm or make elections to ensure benefit coverage during the current and upcoming plan years. If you have any questions, please call the Benefits Resource Line and speak with a Benefits Specialist.

Pathways to Enrollment: Enrolling Step-by-Step

You Can Click or Call to Enroll

Open Enrollment is a paperless process. This means that you can enroll through the County of Orange Benefits Center in two ways:

- On the Web — You can enroll online at the Benefits Center Web Site any time during Open Enrollment.
- By phone — You can call the toll-free Benefits Resource Line and speak to a Benefits Specialist. Benefits Specialists are available Monday through Friday, from 7:30 a.m. to 5:30 p.m., Pacific Time, except for holidays.

When to Click or Call

The Benefits Center makes it easy to enroll and get information about your benefits. You can enroll or find information about your benefits on the Benefits Center Web Site or on the Benefits Resource Line. If you need help and can't find the information you need on the automated system, you may speak to a Benefits Specialist.

Here's a summary of the types of information available and the kinds of changes you can make — online or by phone.

	Log on to the Benefits Center Web Site to…	Call the Toll-Free Benefits Resource Line to…	Speak to a Benefits Specialist to…
Review your automatic benefit coverage	✔	✔	✔
Find out the cost of your benefit elections	✔		✔
Confirm who is covered under your benefit plans	✔	✔	✔
Enroll for coverage during enrollment period	✔		✔
Use tools such as Select-a-Plan to help you make decisions about your benefits	✔		
View health plan Provider Directories	✔		
Report most life event changes	✔		✔
Change dependent information	✔		✔
Request forms	✔	✔	✔
Find answers to your questions about benefits	✔		✔

What to Have with You When You Enroll

When you enroll, you should have the following items handy:

- Your Social Security number
- Your Benefits Enrollment Summary
- Your Personal Identification Number (PIN)

If you're electing the CIGNA Health Plan HMO, you must select a Primary Care Physician (PCP) for each covered person and enter that PCP's identification (ID) number when you

enroll. You can find a list of PCP ID numbers on the Benefits Center Web Site by following the links to provider sites or by going directly to the CIGNA Web Site.

Benefits Enrollment Summary

Your personalized Benefits Enrollment Summary is a valuable tool to help you make your choices. You'll find your Benefits Enrollment Summary in your enrollment package. This summary shows:

- Your automatic benefits coverage
- The benefits you're eligible to enroll in
- Your cost for each benefit.

You will be enrolled in the automatic benefits coverage shown on your Benefits Enrollment Summary if you do not make any changes before the deadline.

You can also access your Benefits Enrollment Summary on the Benefits Center Web Site. If you can't find your PIN, call the Benefits Resource Line, press **0, and speak with a Benefits Specialist.

▶ **How to Change Your PIN**

When you log on to the Benefits Center Web Site or call the Benefits Resource Line for the first time, you'll be prompted to change your PIN. You can also change your PIN any time you want. You have two ways to change your PIN:

- Online — Log on to the Benefits Center Web Site and follow the instructions to change your PIN.
- By phone — Call the Benefits Resource Line and follow the instructions to change your PIN.

Because your PIN provides access to your personal information, please remember to keep it confidential at all times.

The first time you log in with your PIN, you should also register for the "Forgot Your PIN?" feature. This will help you recover your PIN should you ever forget it.

How to Read Your Benefits Enrollment Summary

Your personalized Benefits Enrollment Summary lists your name and address in the upper left corner. Below that, the summary shows your automatic benefits — the benefits you'll receive if you don't make any changes at the enrollment period. For each benefit, the summary also shows your coverage level and your before- and after-tax cost (if applicable).

The next section lists all the benefits for which you're eligible, including option numbers and cost by coverage level.

Carefully review the benefits for which you're eligible before you enroll. You can even highlight your benefit selections on your summary so that you can quickly and easily reference them as you enroll.

How to Enroll through the Benefits Center Web Site

At the Benefits Center Web Site, you have information right at your fingertips. You can access the site from any computer with Internet access, at home or at work. To begin online enrollment:

1. Go to **www.benefitsweb.com/countyoforange.html**
2. When prompted, enter your Social Security Number and Personal Identification Number (PIN).
3. The first time you log on to the Web Site, you'll automatically be prompted to change your PIN.
4. Follow the instructions for enrollment from there.

Steps to Enroll Online

From the Open Enrollment section of the Benefits Center Web Site, you can do the following:

- Get an overview of the benefits available to you.
- Compare health plans and plan features that are important to you. You can also use the "Compare/Evaluate Health Plans" feature to help select a health plan based on those factors that are most important to you.
- Read PPO plan documents and HMO Group Service Agreements that provide detailed information about your County of Orange benefit plans.
- Make changes to your benefit elections and/or dependent information.
- Review your elections, including a list of all the benefits you are eligible for through the County of Orange. The benefits you see are the benefits you will receive in the upcoming calendar year unless you make changes during Open Enrollment.
- Use the "Model a Life Event" tool to help you plan for the future. Enter different scenarios and find out how each would affect you financially. For example, you can determine what your health plan cost would be if you added a dependent.

After you have made your benefit elections, you will see a Benefits Confirmation Statement. Your Confirmation Statement from the Web Site will have a number assigned to it. This will ensure you have properly saved your elections. Print a copy of this statement for your records. You'll also receive a Benefits Confirmation Statement in the mail shortly after making your elections.

Web Tools

Good looks and speed are just the beginning of the improvements to your County Benefits Center Web Site. Here are some of the great tools that you'll have at your fingertips, anytime night or day.

Select-a-Plan

This tool compares features and estimates your costs under the various County health plans available to you so you can make enrollment decisions that best fit your needs. With the Select-a-Plan tool, you can perform "Preference Modeling". By answering questions about what you want in a health plan, the tool determines which of the available options is best suited for you. Compare plans side-by-side. Use this overview of the benefit features that are important to you to see how your health plan options stack up against one another. Estimate your costs. Use the "Cost Calculator" to estimate costs based on benefit features and your estimate of the medical services that you and your family will use.

Healthcare Advisor

You can use the Healthcare Advisor tool on the Benefits Center Web Site to research medical conditions or procedures. Use this tool when you become aware of a health issue to learn about treatment options, risks, the recovery process and to find suggestions for questions you should ask your provider or insurance company. The tool even lists those hospitals rated the best in treating a given condition.

The Healthcare Advisor also has a medical encyclopedia with additional information on various medical terms including diseases, symptoms, tests, surgical procedures, and more.

* Web Tools not available to RME/RMR's/retirees with Medicare.

How to Use the Benefits Resource Line

With the Benefits Resource Line, you can:

- Enroll, change your dependents, or ask questions by speaking to a Benefits Specialist
- Review your elections, change your PIN, and request forms through the automated system.

To use the Benefits Resource Line:

1. Dial the toll-free phone number, **1-866-325-2345**.
2. Enter your Social Security number and PIN when prompted. If this is your first time calling the Benefits Resource Line, you'll be prompted to change your PIN.
3. Listen to the list of available options and select the one you need.

Your Benefits Confirmation Statement

You'll receive a Benefits Confirmation Statement in the mail shortly after you enroll (or at the end of Open Enrollment if you did not make any Open Enrollment elections). Review this statement carefully to make sure it's accurate. If you find an error in the elections you made or if you make an election and don't receive a statement within 10 business days, call the Benefits Resource Line right away and speak to a Benefits Specialist. You'll have 10 business days from the date of your statement to report errors in elections you've made.

How the Pathways to Benefits Program Works

The County currently provides a Retiree Medical Insurance Program to help you take care of and protect yourself and your family. If you're eligible, the County's Retiree Medical Insurance Program benefits include retiree health plan coverage and the Retiree Medical Plan to help you pay for your County health plan coverage and/or Medicare premiums.

Your age and Medicare eligibility affect the benefits for which you're eligible. Be sure to read this section of this guide carefully so you'll have the information you need to make the right choices for your situation.

Who Is Eligible?

Retiree Health Care Coverage

As a retiree of the County, you're eligible for County retiree health care coverage if you:

- Were enrolled in a County health plan at the time you retired and
- Receive a monthly retirement allowance from the Orange County Employees Retirement System (OCERS).

Your eligible dependents for retiree health coverage include your:

- Legal spouse or Domestic Partner
- Unmarried children under age 19 (or under age 23 if full-time student), including step children, foster children, children placed for adoption, and legally adopted children. children who are full-time students must attend an accredited school, college or university (12 units or more) and must be dependent on you for financial support to continue to be covered
- Unmarried incapacitated children of any age if they depend on you for financial support, are enrolled in your health plan when you retire, and were incapacitated prior to age 19.

Proof of adoption, domestic partnership, or legal guardianship may be requested at any time. Dependents over age 19 who are students may be required to provide proof of full-time student status to the County Benefits Center at any time.

Retirees must notify the Benefits Center within 30 days of a dependent no longer meeting eligibility requirements. The retiree must use the Benefits Center Web Site or Benefits Resource Line to disenroll an ineligible dependent.

Domestic Partner Coverage

The County of Orange offers many of the benefits described in this guide to the domestic partners of eligible employees and retirees. Benefits available to a spouse and eligible dependent children are also available to a domestic partner and his or her eligible dependent children. Coverage may include health care (including prescription drug) and dental coverage.

What Is a Domestic Partnership?

In California, a domestic partnership is established when two people file a "Declaration of Domestic Partnership" with the Secretary of State and meet a number of legal requirements. The partners must, among other things, share a common residence, be at least 18 years of age, not be blood-related in a way that would prevent them from being married to each other in California, and be of the same sex (unless one of them is over age 62 and at least one of them is eligible for Social Security retirement benefits).

The County also recognizes domestic partnerships that are valid in other states, so long as they are substantially the same as California domestic partnerships.

Enrolling a Domestic Partner

If you want coverage for a domestic partner and his or her eligible children, you may elect it when you first enroll for benefits, during any Open Enrollment period, Qualified Life Event, or within 30 days of establishing your domestic partnership.

To enroll, you must call the Benefits Resource Line and affirm that you have a valid California "Declaration Of Domestic Partnership" or similar document from another state. You may be asked to provide a copy of the document to verify eligibility.

If you and your domestic partner are both benefit-eligible County employees or retirees, you must follow the same rules for dual coverage that apply to married couples working for or retired from the County. Also, the coverage and enrollment or disenrollment rules under the applicable EME, RME, or RMR Program pertain to you.

Effect on Taxes

If you are not allowed to claim your covered domestic partner and his or her children as dependents on your federal income tax return, you will have to pay federal tax on both the County's contributions and any before-tax contributions you make toward the cost of their health care coverage. The value of these contributions will be reported to the IRS as "imputed income." If you prefer, you may elect to make your own contributions on an after-tax basis. After-tax contributions are not taxable as imputed income. However, County contributions will still be subject to imputed income.

County contributions towards domestic partner coverage are not taxable for California state income tax purposes. You will see imputed income for any before-tax contributions you make towards the cost of your domestic partner's health coverage. Tax laws for other states vary.

You should consult with your tax advisor in connection with the tax effect of domestic partner benefits offered by the County. The County cannot provide you with any tax advice.

For More Information

If you need more information about domestic partner coverage, call the toll-free Benefits Resource Line at 1-866-325-2345 to speak to a Benefits Specialist. Benefits Specialists are available Monday through Friday, 7:30 a.m. to 5:30 p.m. Pacific Time, except holidays.

Retiree Married to an Employee (RME)

If you're a retiree married to a County employee, you must let the County know your status by calling the Benefits Resource Line and speaking with a Benefits Specialist. If you're eligible to be enrolled as a dependent on your spouse's County health plan, you may elect either to be enrolled individually in a retiree health plan with your Retiree Medical Plan Grant or to be enrolled as a dependent under your spouse's employee health plan. Active employee pays normal bi-weekly deductions.

If you elect coverage as a dependent on your spouse's County health plan, your Retiree Medical Plan Grant will be suspended. If you later enroll in the retiree health plan (during annual Open Enrollment or within 30 days after a Qualified Life Event), your Retiree Medical Plan Grant will be reinstated at the start of the new plan year or on the first of the month following the Qualified Life Event.

Retiree Married to a Retiree (RMR)

If you're a County retiree married to another County retiree, you must let the County know your status by calling the Benefits Resource Line and speaking with a Benefits Specialist. If you and your spouse enroll in the same County retiree health plan, one of you must be enrolled as a subscriber and the other must be enrolled as a dependent. You may combine your Retiree Medical Plan Grants. You may also choose to enroll in different County health plans and use your Retiree Medical Plan Grants separately.

RME and RMR Participants Must Enroll on the Benefits Resource Line

If you're a retiree married to an employee (RME) or a retiree married to a retiree (RMR) from the County, you won't be able to enroll in your health plan online — you must call the Benefits Resource Line and speak to a Benefits Specialist.

If you're participating in the RME or RMR program for the first time, you must call the Benefits Resource Line to make your election prior to sending in your RME or RMR form, available on the Benefits Center Web Site. If you're a current retiree, you'll need to return your form to the Benefits Center by the Open Enrollment deadline. If you're a new retiree, you'll need to return your form to the Benefits Center within your 30-day enrollment period.

Retiree Medical Plan Grant

When you retire, you may be eligible to receive a Retiree Medical Plan Grant (Grant) to use toward the cost of your County health plan and/or your Medicare premium. To be eligible for the Grant, you must:

- Have a minimum of 10 years of continuous eligible County service, if you have a normal retirement. However, if you've been granted a non-service-connected disability, you must have a minimum of five years of service. If you've been granted a service-connected disability, there is no minimum-service requirement,
- Be at least 50 years old on your date of retirement,
- Receive a monthly retirement allowance from the Orange County Employees Retirement System (OCERS), and
- Be enrolled in a County health plan when you retire.

- The amount of the Retiree Medical Plan Grant you receive is based on your years of eligible County service hours to a maximum of 25 years of service multiplied by a base dollar amount. The base dollar amount is adjusted up or down annually up to a maximum of 3% beginning January 1, 2008.
- The Retiree Medical Plan Grant will be applied first to offset the cost of your and/or your spouse's County health plan premium. Any remaining monthly Grant will be applied to your Medicare premium reimbursement, if applicable. You cannot receive the Medicare reimbursement if you're currently receiving Medicare reimbursement from another source.
- If the total of your monthly County health plan premium and your monthly Medicare premium reimbursement is less than the total monthly Retiree Medical Plan Grant, the excess Grant is forfeited.

Retirees who gain health coverage elsewhere following retirement and who wish to use their Grant to reimburse Medicare premiums will be required to enroll in Medicare once eligible. Both the subscriber and an eligible dependent must enroll in Medicare A & B (Part A, if at no cost), even if they are actively working with coverage elsewhere.

50% Reduction of the Grant when Medicare Eligible*

This section does not apply if you and your spouse are both retired and age 65 at the time the Board approved the 2006 Retiree Medical Restructuring changes.

If you were retired and age 64 at the time the Board approved the 2006 Retiree Medical Restructuring changes your Grant will be reduced by 50% once you become eligible for Medicare Parts A&B (Part A, if at no cost to you) but no sooner than October 1, 2007. (November 1, 2007 for employees or retirees represented by International Union of Operating Engineers (IUOE).

All other retirees who are eligible for both Medicare Parts A&B (Part A, if at no cost to you) will have a 50% reduction in their monthly Grant the first day of the month in which they turn 65.

7.5% Reduction or Increase in the Grant *

For non-safety employees retiring after September 12, 2006 and represented by the Orange County Employees Association (OCEA) or the Service Employees International Union (SEIU) and September 26, 2006 for employee represented by the Orange County Managers Association (OCMA) or the Orange County Attorneys Association (OCAA) or covered by the Personnel Salary Resolution and October 24, 2006 for International Union of Operating Engineers (IUOE) there will be a 7.5% reduction to the Grant for each year retiring before 60 years of age; and a 7.5% increase to the Grant for each year worked after age 60 up to age 70. Safety retirees will not be subject to the 7.5% reduction or increase.

* The effective date may vary depending on your bargaining unit or employer (County, Special District or Court).

Survivor Benefits

If you're a survivor of a deceased employee or retiree, you may be eligible for coverage under a County retiree health plan and for a Retiree Medical Plan Survivor Grant. The Survivor Grant is equal to 50% of the Grant the deceased would have been eligible to receive.

Survivor Health Care Coverage

To be eligible for survivor health plan coverage, you must:

Be covered under the deceased employee's or retiree's County health plan at the time of his or her death

Receive a monthly retirement allowance from OCERS, exceptions to this rule include:

- Dependent children under age 19 (or under age 23 if a full-time students) who aged out of receiving a monthly retirement allowance from OCERS but are still eligible under the plans
- Incapacitated children and surviving spouses who aren't eligible for a monthly retirement allowance but are eligible for health plan coverage

Survivor Retiree Medical Grant Benefits

To be eligible for a Survivor Grant, you must:

- Be a survivor of a deceased Grant-eligible County employee or retiree.
- Receive a monthly retirement allowance from the OCERS, and
- Are covered under the employee's or retiree's County health plan at the time of his or her death.

▶ Important Medicare Information

This section provides important information about Medicare and how it affects the cost of your retiree health care coverage and your Retiree Medical Plan Grant. Be sure to review it carefully.

If you have any questions, visit the Benefits Center Web Site or call the Benefits Resource Line to speak with a Benefits Specialist.

Enrolling in Medicare

All eligible retirees and their dependents who are age 65 or older must be enrolled in Medicare Part A & B (Part A if eligible, at no cost) or Part B only to be eligible to receive a Retiree Medical Plan Grant (enrollment in Medicare may also apply to some disability retirements). You and your spouse have 90 days from the date of your retirement (if age 65 or older) or from your or your spouse's 65th birthday to enroll in Medicare. Retirees who gain health coverage elsewhere following retirement will be required to enroll in Medicare once eligible. If either the subscriber or the dependent is eligible for Medicare each must enroll (Part A, if at no cost), even if they are actively working with coverage elsewhere.

You may be asked to submit documentation of your Medicare enrollment. Failure to submit proof of Medicare coverage (e.g., a copy of your Medicare card) will result in suspension of your Retiree Medical Plan Grant and automatic enrollment in an applicable health plan.

Medicare has three parts:

- Part A — Provides basic benefits for inpatient stays in hospitals and skilled nursing facilities to those who qualify (people with 40 credits under Social Security or about 10 years of work or whose spouse is eligible for Medicare). Part A is provided as part of your Social Security benefits.
- Part B — Supplements Part A coverage for certain outpatient medical needs such as physician services, physical therapy, diagnostic X-rays and laboratory and other tests. You are responsible to pay a monthly premium for Part B coverage.
- Part D — A voluntary prescription drug benefit to everyone enrolled in Medicare Parts A & B and/or Part B only. This benefit became available on January 1, 2006. Retirees over age 65 with Medicare Parts A & B and/or Part B only enrolled in the Premier Wellwise, CIGNA, or the Kaiser Senior Advantage plans should not enroll in Medicare Part D since they have their prescription drug coverage through their County retiree health plan.

▶ **Make Your Life Easier: Get a Head Start on Medicare Enrollment**

Be sure to contact the Social Security Administration 90 days before your or your spouse's 65th birthday (or retirement date if retiring after age 65) to begin the process of enrolling in Medicare. (The phone number is listed under "Helpful Information" at the end of this guide.)

Benefits of Medicare

Once you've enrolled in Medicare, your health care premiums will be significantly reduced. The amount of reduction varies depending on the County health plan in which you're enrolled.

If your Retiree Medical Plan Grant is greater than your County health plan premium, you can use the excess grant to offset your Medicare premium (provided you aren't receiving reimbursement from another source).

Retiree Health Plan Options

The County offers two types of retiree health care plans:

- Health Maintenance Organization (HMO) plans and
- Preferred Provider Organization (PPO) plans.

The chart below shows the plans that may be available to you, depending on your Medicare eligibility and where you live.

Medicare and the Kaiser Health Plans

The Kaiser HMO is only available to retirees and their spouses under age 65. A Kaiser HMO participant who reaches age 65 will be offered the Kaiser Senior Advantage HMO with Medicare Part D as a replacement.

The key facts for being enrolled with Kaiser Senior Advantage are:

- Participants do not have to do anything, their enrollment into Medicare Part D is part of their KP enrollment
- The Prescription benefit that they have with the addition of Medicare Part D is no different than prior to Medicare Part D
- There is no additional cost for this program
- Kaiser Senior Advantage participants will receive a new Kaiser ID card indicating their Medicare Part D status

Kaiser Senior Advantage requires that you assign your Medicare Parts A & B or Part B only to the Kaiser health plan. This means you cannot use Medicare to reimburse you for medical services that are obtained outside of Kaiser Senior Advantage facilities and providers. In exchange, your premium for this plan is lower than the premium for other HMOs. Other County plans do not require assignment of your Medicare benefits, but do require that you be enrolled in Medicare, if eligible. These other County plans will coordinate your benefits with Medicare. See the Kaiser Senior Advantage HMO section later in this guide for more information.

▶ 2006 Medicare Part D Subsidy

On December 8, 2003, President Bush signed the Medicare Modernization Act (MMA) into law, significantly expanding Medicare by adding a voluntary prescription drug benefit under a new Medicare Part D available to retirees enrolled in Medicare Parts A & B and/or Part B only.

The new prescription drug benefit began January 1, 2007, with the first enrollment occurring in the fall of 2006. To slow the decline in the number of employer-sponsored retiree health plans, the government will pay an employer that sponsors a qualified retiree prescription drug plan a tax-free subsidy.

Retirees over age 65 with Medicare Parts A & B and/or Part B only enrolled in the Premier Wellwise and CIGNA plans **should not** enroll in Medicare Part D since they have their prescription drug coverage through their County retiree health plan.

Retirees over the age of 65 with Medicare Parts A & B and/or Part B only and enrolled in Kaiser Senior Advantage health plan will automatically be enrolled in Medicare Part D by Kaiser. Retirees over age 65 **should not** enroll themselves in Medicare Part D. Since the Kaiser Senior Advantage plan is a Medicare Advantage plan, Kaiser will pass the Medicare Part D savings through a reduction in the rates for retiree and spouses, if eligible over the age of 65 with Medicare Parts A & B and/or Part B only.

Retirees age 65 or older with Medicare Parts A & B and/or Part B only and enrolled in the Premier Sharewell health plan **should** enroll in Medicare Part D because the Premier Sharewell plan has a $5,000 deductible per family per year.

The County of Orange Benefits Center will send you a letter of Credible Coverage to your home address. This letter is your proof that you have County prescription drug coverage that, on average, is as good as Medicare coverage. You will want to retain this letter for your personal records. And, **should** you join a Medicare prescription drug plan at a later date, you may do so without paying a penalty. If you ever enroll in one of the new prescription drug plans approved by Medicare after the May 15, 2006 date or when you dis-enroll from a County health plan, you may need to present a copy of this notice when you join to show that you are not required to pay a higher premium.

Health Plan	With Medicare A and B or B Only	Without Medicare A and B or B Only	If You Live Outside of California OR If You Live in California but Outside of the HMO Service Area (with or without Medicare)
HMO Plans			
CIGNA Health Plan	✔	✔	
Kaiser Health Plan		✔	
Kaiser Senior Advantage	✔		
PPO Plans			
Premier Wellwise	✔	✔	✔
Premier Sharewell	✔	✔	✔

How HMO Plans Work

HMO plans provide a comprehensive array of services, including preventive care, at a minimal cost but you must use only providers in the HMO plan network. An HMO network includes doctors, hospitals, and other health care providers and facilities that have contracted with the HMO to provide care at lower rates. HMOs do not generally pay benefits for care received outside the HMO network, except in emergency situations.

Some important features of HMO plans include:

- Minimal copayments for certain services (e.g., doctor's office visits)
- No claim forms
- Covered preventive services such as annual physicals, Well-baby and Well-Woman care and immunizations
- No lifetime maximums
- No pre-existing condition exclusions

Your HMO Options

At the County, you have three HMO plans to choose from:

- CIGNA Health Plan HMO (CIGNA HealthCare of Southern California and San Diego)
- Kaiser Health Plan HMO (for retirees under age 65 and not enrolled in Medicare unless disabled)
- Kaiser Senior Advantage (requires enrollment in Medicare Parts A & B or Part B only).

CIGNA Health Plan HMO

Highlights of the CIGNA Health Plan HMO:

- You select a Primary Care Physician (PCP) from the CIGNA network to provide and/or coordinate all your care, including diagnostic tests, referrals to specialists and hospitalizations. With the exception of emergency treatment, self-referrals to OB/GYNs within the same medical group for Well Woman exams and mental health services your PCP must authorize, provide, and/or arrange all of your care in order for you to receive benefits.

- When you need care, you contact your PCP's office. At your appointment, present your ID card and pay a small copayment.
- Schedule an appointment with an OB/GYN in the same medical group as your PCP without a referral.
- When medication is prescribed, you must fill the prescription at a CIGNA contracted retail pharmacy. You pay a small copayment for up to a 30-day supply of medication. For a list of CIGNA pharmacies, log on to the CIGNA Web Site or call CIGNA Member Services.
- For maintenance-type prescription drugs, you can order up to a 90-day supply of your medication through CIGNA's mail order program. You can call CIGNA's toll-free number or place your order online through CIGNA's Web Site.
- In an emergency, seek care at the nearest hospital and call or have your doctor or family call your PCP or CIGNA Member Services within 48 hours to receive benefits.
- If you need vision care, call Vision Service Plan (VSP).
- Chiropractic care is covered. See details later in this section.

▶ How to Locate a CIGNA PCP

If you're electing the CIGNA Health Plan HMO for the first time or adding a dependent, you'll need to enter this PCP information when you enroll. CIGNA PCP listings are available on the Benefits Center Web Site or by contacting Cigna.

Kaiser Health Plan HMO

Highlights of the Kaiser Health Plan HMO:

- Health services must be provided by Kaiser providers, but is not necessary to select a Primary Care Physician upon enrollment.
- When you need care, either contact your Kaiser primary care physician or the Kaiser appointment center in your area. At the time of your appointment, present your ID card and pay a small copayment. You can access any Kaiser office for care.
- You can self-refer to a number of specialists, including OB/GYN, internal medicine, optometry, and mental health (varies by location).
- You have access to the Kaiser's Web Site (www.kp.org), which offers both health and member information. You can schedule appointments, get health education information, and receive other valuable services. Health information is also available through Kaiser's toll-free number.
- You must fill prescriptions at any Kaiser pharmacy, located at each medical office. You pay a small copayment for up to a 100-day supply of a prescription drug. Dental prescriptions are included in your coverage..
- In an emergency, seek care at the nearest hospital. Call or have your doctor or family call Kaiser as soon as possible to receive benefits. Your Kaiser coverage is worldwide.

- Kaiser covers chiropractic care.

▶ **Chiropractic Care**

Under the CIGNA and Kaiser HMOs, you have direct access to a network of more than 2,400 California chiropractors through American Specialty Health Plans (ASHP). You simply contact an ASHP chiropractor, make an appointment, and pay your copayment at each visit. For a listing of participating chiropractors, visit the Benefits Center Web Site for a link to the American Specialty Health Plans Web Site or call ASHP Customer Service, Monday through Friday, 5 a.m. to 8 p.m., or Saturday, 6 a.m. to 3 p.m., Pacific Time.

Kaiser Senior Advantage HMO

(Available to Retirees Enrolled in Medicare Parts A and B or B Only)

Under the Kaiser Senior Advantage HMO, you must use the plan's contracted providers for all medical services except emergencies or urgent care. Because Kaiser Senior Advantage HMO is a Medicare assignment plan, benefits are paid only for health care received through the network, and you can't use Medicare to reimburse yourself for medical services you obtain from out-of-network providers.

This plan is designed especially for seniors and features:

- Hospital and physician services
- Prescription drug coverage with no annual limit
- No claim forms to fill out
- Enhanced benefits such as dental care, hearing exams, podiatry, and hospice care
- Preventive care and wellness programs.

Highlights of the Kaiser Senior Advantage HMO:

- You and your covered dependents must be enrolled in Medicare Parts A and B or part B only and live in Kaiser's California service area. You also must assign your Medicare benefits to Kaiser.
- Health services must be provided by Kaiser physicians and hospitals. You do not need to select a Primary Care Physician (PCP) to coordinate your care. Provider directories are available on the Employee Benefits Web Site.
- When you need care, contact the Kaiser appointment center in your area. At your appointment, present your ID card and pay a small copayment.
- You can also go to Kaiser specialists who provide OB/GYN, dermatology, optometry, or mental health services without a referral.
- Members have access to "KP Online" — a Web Site that offers health information and allows you to schedule appointments. You can also get this information via Kaiser's toll-free phone number.
- When medication is prescribed, you must fill the prescription at a Kaiser pharmacy. You pay a copayment for up to a 100-day supply. Dental prescriptions are included in your coverage.
- In an emergency, seek care at the nearest hospital and call or have your doctor or family call Kaiser within 24 hours to receive benefits.
- Kaiser covers chiropractic care.

For more details on the HMO plan options, see the Health Plans At-a-Glance comparison chart later in this guide.

How the PPO Plans Work

Preferred Provider Organizations (PPOs) give you the freedom to choose any doctor, whether or not he or she is a member of the PPO network, but you receive a higher level of benefits from in-network doctors. You do not need to select a PCP to coordinate your care and you can see a specialist any time you wish.

Important: The pre-existing Condition Clause, applies:

For the PPO health plans if you enroll in a PPO plan outside the Open Enrollment period or if there is a lapse in County of Orange health coverage.

When You See an In-Network Provider, You…	When You See an Out-of-Network Provider, You…
Pay an annual deductible before the plan pays benefits	Pay an annual deductible before the plan pays benefits
Receive a higher level of benefits	Receive a lower level of benefits
Pay a percentage of a negotiated fee for services	Must pay a percentage of Usual, Reasonable and Customary (URC)* charges plus any amounts above URC charges
Have less paperwork (provider processes the paperwork and submits claims)	Pay up front, file a claim form, and wait for reimbursement (if any)

*Usual, Reasonable and Customary charges are the usual charges to provide a health service in your geographic area as determined by the plan. When providers join the PPO network, they agree to accept the negotiated fee as payment in full for covered services.

Your PPO Options

You have two PPO plans to choose from:

- Premier Wellwise PPO
- Premier Sharewell PPO.

Highlights of the PPO plans:

- When you need care, you can go to a provider in (PPO) or out (non-PPO) of the UnitedHealthcare Choice Plus preferred provider network. Although the PPO plans have the same provider network, they have different deductibles and coinsurance amounts. See the Health Plans At-a-Glance comparison chart for details.
- When you see a PPO provider, present your ID card at the time of your appointment. Your provider files the paperwork for your claim and you receive a bill in the mail for your deductible and/or coinsurance amount — 10% of the discounted rate for most covered services.
- When you see a non-PPO provider, you generally pay 20% of the usual, reasonable and customary charge for most covered services and, in some instances, may have to pay up front.
- Both PPO plans pay 100% of eligible health care expenses that are in excess of $10,000 per calendar year per participant.
- If you're scheduled for hospital admission or surgery, you must contact the claims administrator, UnitedHealthcare, to obtain precertification for the hospital stay before admittance in order to receive the higher level of benefits.
- In an emergency, seek care at the nearest hospital and call or have your doctor or family call UnitedHealthcare's Customer Service Center within two business days of admission to a hospital.

▶ **UnitedHealthcare Choice Plus Network (PPO)**

Each of the County PPO plans uses the UnitedHealthcare Choice Plus (PPO) as its preferred provider organization network. UnitedHealthcare Choice Plus includes more than 4,700 hospitals and 500,000 physicians across the country. You can use the provider directory on UnitedHealthcare's Web Site to find out which hospitals and doctors are in the network, or you can call UnitedHealthcare's Customer Service Center for assistance.

Prescription Drug Benefits — Premier Wellwise PPO

If you enroll in the Premier Wellwise PPO, Walgreens Health Initiatives, (WHI) will administer your prescription drug coverage. WHI offers discount prices on name brand and generic drugs with no annual deductible and no claim forms. WHI also has a large network of more than 54,000 pharmacies throughout the country, including most major pharmacies like Rite-Aid, Sav-on, CVS, and Costco and offers state-of-the-art mail order facilities.

You must fill your prescriptions through WHI's participating retail pharmacies or through their mail service program. Please note: you do not need to go to a WHI's pharmacy but you can use any participating pharmacy in the WHI's pharmacy network. Prescriptions obtained as a result of an emergency must be filed with UnitedHealthcare, the PPO claims administrator. When you purchase prescription drugs from a Walgreens participating retail pharmacy, you will always present your health plan ID card to the pharmacist. Advantage90 Program is a convenient way to get a 90-day supply of your medications at select retail locations. (Your doctor must authorize a 90-day supply of medication(s). Some medications may not be available in 90-day supplies under applicable law.) This is a great way to save time and money and for more information please visit WHI's web site at **www.mywhi.com** or call toll free 1-800-573-3583 with any questions you might have. For mail service prescription drugs, or if you have a new "maintenance" medication prescription, you may use WHI's Mail Order program.

Here's an overview of WHI's prescription drug coverage:

Premier Wellwise Prescription Drug Benefits			
Type of Medication	30-Day Retail Coinsurance	90-Day (Advantage90) Retail Coinsurance	90-Day Mail Service Coinsurance
Generic drugs	20%	20%	20%
Brand name drugs	20%	20%	20%

You always save money by using generic drugs (if available) instead of name brand drugs. Although you pay the same coinsurance for generic and name brand drugs, you pay less for generic drugs because they cost less. Additional discounts may be available for maintenance drugs through WHI's Mail Order Program and with mail service you enjoy the additional convenience of being able to order refills online.

Prescription Drug Benefits — Premier Sharewell PPO

If you enroll in the Premier Sharewell PPO plan, UnitedHealthcare administers your prescription drug coverage and you can fill your prescriptions at any retail pharmacy. You pay the cost of the prescription up front, then send a claim form with attached receipts to UnitedHealthcare and wait for reimbursement. You must satisfy the annual deductible before the plan pays 80% of the cost of covered prescription drugs.

Things to Consider If Selecting a PPO Plan

Although the County's PPO plans are very similar, there are some differences in benefits, such as different deductibles, coinsurance, and prescription drug coverage. Here are two examples:

- The Premier Wellwise PPO offers wellness incentives — up to a $200, $400, or $500 taxable incentive, depending on the level of coverage you elect — if you or your enrolled dependents don't file any claims or fill prescriptions using your prescription drug card and mail order program during the year, as well as a $50 year-end taxable cash incentive for non-smoking subscribers.
- The Premier Sharewell PPO has a $5,000 annual deductible per family and is designed for retirees who have Medicare coverage or other health insurance coverage but want to supplement their family's coverage.

Because of these differences, it's important to review the Health Plans At-a-Glance comparison chart if you're thinking about electing a PPO plan.

▶ **Health Plan Decision Guidelines**

Here are some things to think about as you decide which health plan is right for you:

• Are the doctors and specialists your family prefers part of the network? If not, are you willing to change doctors?

• Are network facilities close to your home?

• How much do you and your family typically spend on health care each year? How much are you willing to pay out-of-pocket in health care expenses? Remember that the PPO plan pays a higher percentage of expenses when you use network providers. HMOs require flat copayments for most services, with no deductible, but you must use HMO providers.

• What do you value more — having the lowest possible out-of-pocket costs (HMO options) or the flexibility to see any provider (PPO options)?

Health Plan Identification Cards and Claim Forms

All participants enrolled in the Premier Wellwise and Premier Sharewell will receive a new identification (ID) card for the new plan year. If you need a replacement card or the information on the card you receive is incorrect, contact your health plan's Member Services directly.

If you are switching health plans during Open Enrollment, you will receive a new ID card.

If you are a new retiree, you will receive an ID card for the health plan you selected.

If you're required to submit a claim to receive plan benefits, claim forms are available directly from the Benefits Center Web Site or by calling the Benefits Resource Line.

Health Plans At-a-Glance

Special Plan for Retirees With Medicare A and B or B Only

Kaiser Health Plan offers a health plan specifically designed for retirees who are covered under Medicare Parts A and B (or Part B only) and live in the approved Southern California service area.

This health plan is especially designed with enhanced benefits for seniors. In addition to basic coverage, the plan may offer limited: • Dental care • Hearing exams • Hospice care • Podiatry

Kaiser Senior Advantage**	
Benefit	**You or Your Dependents Pay:**
Medicare	Requires Medicare Parts A and B, or B only
Maximum Lifetime Coverage	No Dollar Limit
Calendar Year Deductible	No Deductible
Hospital Services	
• Inpatient • Outpatient • No Precertification Review	$100 Per Admission $15 Charge N/A
Physician Care	
• Office Visits • Second Opinion • w/o Second Opinion • Well-Baby Care • Diagnostic X-rays/Lab • Immunizations	$15 Per Visit $15 Per Visit N/A No Charge to 23 Months No Charge No Charge
Durable Medical Equipment	No Charge
Routine Exams — Adults	
• Annual Physical • Prostate Screening • Well-Woman Exams	$15 Charge $15 Charge $15 Charge Note: For well-woman exams, may self-refer to a Kaiser provider.
Maternity Care	$100 Per Admission
Prescription Drugs • Medicare Part D is assigned to Kaiser	$10 Generic Prescription $15 Brand Prescription Up to 100-Day Supply Dental Prescriptions Included

Kaiser Senior Advantage**	
Benefit	**You or Your Dependents Pay:**
Chiropractic	$15 Charge Up to 30 Visits Per Year
Eye Refractions	$150 Frame and Lens Allowance Every 24 Months, Exam $15 Charge
Family Planning	
• Contraceptives • Vasectomy • Tubal Ligation • Infertility Services	$10 Generic $15 Brand $15 Charge $15 Charge Limited, $15 Per Visit
Mental Health*	
• Inpatient • Outpatient • Lifetime Maximum	$100 Per Admission, Up to 45 Days $15 Per Visit 190 Days
Alcohol & Drug Abuse	
• Inpatient • Outpatient • Maximum Yearly Outpatient • Lifetime Maximum	$100 Per Admission, Detox Only $15 Per Visit Unlimited N/A
Home Health Care	No Charge
Skilled Nursing Facility	No Charge Up to 100 Days
Emergency Services Ambulance	$50 Charge — Waived If Admitted No Charge

This is a general description and overview of Kaiser Senior Advantage Plan.

*Note: The number-of-days maximum does not apply to certain conditions that are covered same as any other illness in accordance with California Mental Health Parity Act.

**HMO plans: Designed to provide quality comprehensive medical services, routine and preventive care while controlling costs by using either their own doctors or health care centers or by providing services through contractual arrangements with community health care providers.

The following chart provides an overview of your health plan options through the County of Orange. This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

	Preferred Provider Organization (PPO) Plans*				Health Maintenance Organization (HMO) Plans**	
	Premier Wellwise		Premier Sharewell		CIGNA	Kaiser
BENEFIT	PPO Provider	Non-PPO Provider	PPO Provider	Non-PPO Provider	HMO Provider	HMO Provider
Maximum Lifetime Coverage	$1,000,000		$1,000,000		No dollar limit	No dollar limit
	Covered Person Pays:		Covered Person Pays:		Covered Person Pays:	Covered Person Pays:
Calendar Year Deductible	$300 per individual $600 per family		$5,000 per family		No deductible	No deductible
Hospital Services						
• Inpatient	10%	20%	10%	20%	$100 per admission	$100 per admission
• Outpatient	10%	20%	10%	20%	$15 per visit	$15 per visit
• No Precertification Review	40%	40%	40%	40%	N/A	N/A
Physician Care						
• Office Visits	10%	20%	10%	20%	$15 per visit	$15 per visit
• Second Opinion	10%	20%	10%	20%	$15 per visit	$15 per visit
• W/o Second Opinion	40%	40%	40%	40%	N/A	N/A
• Well Baby Care	No charge	Not covered	No charge	Not covered	No charge	No charge to 23 months
• Diagnostic X-rays/Lab	10%	20%	10%	20%	No charge	No charge
• Immunizations	No charge (limited)	Not covered	No charge (limited)	Not covered	No charge	No charge
Routine Exams – Adults	No charge, up to a maximum annual benefit of $250 in-network only ($250 annual limit does not apply to specific procedures listed under "Wellness Benefit" in the plan Document)	Limited to specific procedures listed under "Wellness Benefit" in the plan Document	No charge, up to a maximum annual benefit amount of $250 In-network only ($250 annual limit does not apply to specific procedures listed under "Wellness Benefit" in the plan document)	Limited to specific procedures listed under "Wellness Benefit" in the plan document		
• Annual Physical					$15 charge	$15 charge
• Prostate Screening					$15 charge	$15 charge
• Well Woman Exams					$15 charge Note: Well woman exams are for breast and pelvic only; not complete physicals. May self-refer within designated plan medical group	$15 charge Note: For well woman exam, may self-refer to a Kaiser provider
Prescription Drugs	20%	20%	20%	20%	$10 generic prescription $15 brand prescription 30-day supply	$10 generic prescription $15 brand prescription Up to 100-day supply Dental prescriptions included
	Drug card program					
Maternity Care	10%	20%	10%	20%	$100 per admission	$100 per admission
Emergency Services	10%	20%	10%	20%	$50 per visit Waived if admitted	$50 per visit Waived if admitted
Ambulance	20%	20%	20%	20%	No charge	No charge
Family Planning						
• Contraceptives	Not covered	Not covered	Not covered	Not covered	$10 generic prescription $15 brand prescription	$10 generic prescription $15 brand prescription
• Vasectomy	10%	20%	10%	20%	$15 charge	$15 charge (out patient)
• Tubal Ligation	10%	20%	10%	20%	$15 charge	$15 charge (out patient)
• Infertility Services	Not covered	Not covered	Not covered	Not covered	Limited, $15 per visit	Limited, $15 per visit

	Preferred Provider Organization (PPO) Plans*				Health Maintenance Organization (HMO) Plans**	
	Premier Wellwise		Premier Sharewell		CIGNA Health Plan	Kaiser Health Plan
BENEFIT	PPO Provider	Non-PPO Provider	PPO Provider	Non-PPO Provider	HMO Provider	HMO Provider
	Covered Person Pays:		Covered Person Pays:		Covered Person Pays:	Covered Person Pays:
Mental Health						
• Inpatient	10%	20%	10%	20%	$100 per admission, up to 30 days	$100 per admission, up to 45 days
• Outpatient	50%	50%	50%	50%	$20 per visit	$15 per visit
	up to $50 per visit		up to $50 per visit			
• Maximum Yearly Outpatient	50 visits		50 visits		N/A	20 visits
• Lifetime Maximum	$30,000, combined with Alcohol and Substance Abuse below. Note: The lifetime and visit maximums do not apply to certain conditions that are covered the same as any other illness in accordance with the California Mental Health Parity Act				N/A Note: Lifetime, visit, and day maximums do not apply to certain conditions that are covered the same as any other illness in accordance with the California Mental Health Parity Act	N/A Note: Lifetime, visit, and day maximums do not apply to certain conditions that are covered the same as any other illness in accordance with the California Mental Health Parity Act
Alcohol and Drug Abuse						
• Inpatient	10%	20%	10%	20%	$100 per admission	$100 per admission, detox only
• Outpatient	50%	50%	50%	50%	$15 per visit	$15 per visit
	Up to $50 per visit		Up to $50 per visit			
• Maximum Yearly Outpatient	50 visits		50 visits		Detox only	Unlimited
• Lifetime Maximum	$30,000 maximum benefit combined with Mental Health above					N/A
Home Health Care	10%	20%	10%	20%	No charge	No charge (100 visits/year)
Skilled Nursing Facility	Limited (Limited to 60 days)		Limited (Limited to 60 days)		No charge (Up to 100 days)	No charge (Up to 100 days)
Eye Refractions	Not covered		Not covered		$5 charge Glasses $10	$15 charge
Chiropractic	10%	20%	10%	20%	$15 per visit	$15 per visit
• Frequency Limitations	50 visits per year		50 visits per year		30 visits per year	30 visits per year
• Yearly Maximum	$1,000		$1,000			
Durable Medical Equipment	Covered	Covered	Covered	Covered	Covered at 100% when prescribed by your Primary Care Physician	Not covered
	Contact health plans for further details					

*__PPO Plans:__ Designed to provide freedom to select physicians, specialists, hospitals and other service providers of your personal choice. The PPO plans pay 100% of eligible health care expenses that are in excess of $10,000 per individual per calendar year.

__PPO Provider:__ County PPO Plans use UnitedHealthcare Choice Plus as its Preferred Provider Organization Network. The network consists of individual physicians, laboratories and Provider Organization Network. The network consists of individual physicians, laboratories and hospitals. As part of this network these "preferred providers" have agreed to provide services at rates which are lower than their regular charges. This helps reduce the cost of health care for you, your dependent(s) and the County. You and your dependent(s) pay a lower copayment percentage for PPO network providers. Using a PPO network provider is voluntary. You or your dependent(s) decide whether to use a PPO network provider for health care.

__Non-PPO Provider:__ when you or your dependent choose a health care provider who does not participate in the UnitedHealthcare Choice Plus (PPO) Provider Network, you or your dependent pays a higher coinsurance percentage for non-PPO network providers.

**__HMO Plans:__ Designed to provide quality comprehensive medical services, routine and preventive care while controlling costs by using either its own doctors or health care centers or by providing services through contractual arrangements with community health care providers.

Important Legal Information

Continuing Your Coverage Under COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives you the right to choose continuation of health care coverage if you and/or your eligible dependents lose County coverage. You may continue health care coverage for up to 18, 29, or 36 months, depending on the situation and who is being covered. You would receive a separate COBRA notification within a couple of weeks of the loss of coverage explaining these rights.

If you think your or your dependents' health care coverage will end because an event occurred causing ineligibility under the plan, there are certain things you must do to continue coverage under COBRA. In some cases, you must notify the County of the event. If COBRA is an option for you, you must make an election and pay for coverage within certain time frames.

If you retire or die, the County will notify you and your dependents of your right to continue health care coverage under COBRA. This notification will explain in detail how COBRA works.

If you divorce or legally separate or your child loses dependent status under a group health plan, you or your covered dependents are responsible for notifying the County within 60 days from the date of these events. The County will then notify your dependents of their right to continue health care coverage under COBRA. This notification will explain in detail how COBRA works. COBRA rights will be forfeited if the County is not notified within 60 days of the qualifying event.

If your domestic partnership ends, your domestic partner and his or her children are not eligible for COBRA. However, a qualified beneficiary receiving COBRA coverage under the County Plans may elect COBRA coverage for a domestic partner and his or her children.

For more information, call COBRA Continuation Services at the number listed under "Helpful Information" at the end of this guide.

Health Insurance Portability and Accountability Act (HIPAA)

The Federal Health Insurance Portability and Accountability Act (HIPAA) imposes certain requirements on group health plans. Under HIPAA, a group health plan:

- Is limited in imposing pre-existing condition exclusions
- Must offer retirees and dependents the opportunity to enroll outside of Open Enrollment in certain situations
- Can't discriminate on the basis of health status with respect to eligibility for plan participation and premium costs
- Can't impose discriminatory lifetime or annual benefit limits for participants with mental illness

- Must permit hospital admissions (if otherwise covered by the plan) of at least 48 hours in case of normal deliveries and 96 hours in the case of Cesarean sections.

Under HIPAA, the employer of a self-funded non-federal governmental plan, such as the County's PPO plans, has the option to exempt the PPO plans from any or all of these requirements except for the certification requirement. The County has opted to exempt the PPO plans from HIPAA requirements. Our current plan provisions already provide for hospital admissions of at least 48 hours in the case of normal deliveries and 96 hours in the case of Cesarean sections and will not be changed as a result of the exemption. A summary of current health plan benefits, copayments, and deductibles is included in this guide and is not affected by this exemption option.

The County's HMO plans comply with HIPAA.

Certification of County Group Health Plan Coverage

HIPAA also requires the County to provide certification of coverage for plan participants whenever County health insurance coverage is terminated. This certification will provide evidence of County health insurance coverage and will show the period the subscriber and dependents were covered under the County health plan. If, after the County coverage terminates, a former health plan participant becomes covered under another group health plan that excludes coverage for pre-existing medical conditions, the former plan participant may be required to provide the HIPAA certification when enrolling in his or her new plan.

The HIPAA certification will be mailed by the Benefits Center to the last known address each time coverage is terminated from one of the County's health plans. More information will be provided on the HIPAA certification at that time. Retirees who are currently enrolled in a County health plan will not receive certification until coverage in one of the County health plans terminates.

Women's Health and Cancer Rights Act of 1998

Under the Women's Health and Cancer Rights Act of 1998, you and your dependents' health plan will not restrict benefits if you or your dependent:

- Receives benefits for a mastectomy
- Elects breast reconstruction in connection with a mastectomy.

Benefits will not be restricted provided that the breast reconstruction is in consultation with your or your dependent's physician and may include:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction may be subject to appropriate annual deductibles and coinsurance provisions that are consistent with those established for other benefits under the plan.

Helpful Information

You can find answers to most of your questions about benefits and enrollment by contacting the County of Orange Benefits Center. If you need additional information after contacting the Benefits Center, you can contact the plans directly.

For Questions About…	Click or Call…
Benefits or Enrolling	
• Benefits Center Web Site	**www.benefitsweb.com/countyoforange.html**
• Benefits Resource Line	1-866-325-2345 Benefits Specialists are available Monday through Friday between 7:30 a.m. and 5:30 p.m., Pacific Time, except holidays TDD: 1-800-TDD-TDD4 (833-8334)
• Employee Benefits Web Site	**www.oc.ca.gov/hr/employeebenefits**
Your Health Plans	
• American Specialty Health Plans (HMO chiropractic care)	**www.ashcompanies.com** 1-800-678-9133 P.O. Box 509002 San Diego, CA 92150-9002
• CIGNA Health Plan HMO	**www.cigna.com/countyoforange** 1-800-244-6224 North Brand Blvd. Glendale, CA 91209
• UnitedHealthcare Plan Administrators (claim administrator for the PPO plans and provider network)	**www.myuhc.com/groups/ocppo** 1-888-350-5608 P.O. Box 30882 Salt Lake City, UT 84130
• Kaiser Health Plan	**www.kp.org** 1-800-464-4000
• Kaiser Senior Advantage	**www.kp.org** 1-800-443-0815 Kaiser California Service Center P.O. Box 232400 San Diego, CA 92193
Prescription Drugs	
• Walgreens Health Initiatives, (WHI) (for the Premier Wellwise PPO Plan)	**www.mywhi.com** 1-800-573-3583 P.O. Box 691569 Orlando, FL 32869
Vision Plan	
• Vision Service Plan (CIGNA HMO)	**www.vsp.com** 1-800-877-7195 P. O. Box 997105 Sacramento, CA 95899-7105
Retirement Benefits	
• Orange County Employees Retirement System (OCERS)	**www.ocers.org** 1-888-570-6277 2223 Wellington Ave. Santa Ana, CA 92701
• Retired Employees Association of Orange County (REAOC)	**www.reaoc.org** 714-840-3995

• Social Security Administration (Medicare coverage)	1-800-772-1213
COBRA	
• COBRA Continuation Services	**www.ceridianbenefits.com** 1-800-877-7994 34th Street South St. Petersburg, FL 33711
Billing	
• Benefits Billing Services	**www.ceridianbenefits.com** 1-877-588-0946 3201 34th Street South St. Petersburg, FL 33711

Network Directories Online

You can view network directories for the health plans on the Internet.

To View Network Directories for…	Go to…
CIGNA Health Plan	**www.cigna.com/countyoforange**
Kaiser Health Plan Kaiser Senior Advantage Plan	**www.kp.org**
Premier Wellwise Plan	**www.myuhc.com/groups/ocppo**
Premier Sharewell Plan	**www.myuhc.com/groups/ocppo**

The information in this guide is only an overview of employee benefit plans available to you. The plan documents and insurance policies for each plan provide the detailed, legal information about your coverage. If there is any difference between this guide and the plan documents or insurance policies, the plan documents and insurance policies will govern.

If you have questions regarding deductions or about your monthly retirement allowance, please call the Orange County Employees Retirement System at 1-888-570-6277.